IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

LISA MONAGHAN,

Plaintiff, No. CIV S-03-2019 KJM

vs.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant. ORDER

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Plaintiff seeks judicial review of a final decision of the Commissioner of Social Security ("Commissioner") denying an application for Disability Income Benefits ("DIB") under Title II of the Social Security Act ("Act"). For the reasons discussed below, the court will grant plaintiff's motion for summary judgment, deny the Commissioner's cross-motion for summary judgment, and remand for immediate payment of benefits.

I. Factual and Procedural Background

In a decision dated February 19, 2003, the ALJ determined plaintiff was not disabled.[1] The ALJ's decision became the final decision of the Commissioner when the Appeals

[1] Disability Insurance Benefits are paid to disabled persons who have contributed to the Social Security program, 42 U.S.C. § 401 et seq. Supplemental Security Income ("SSI") is paid

Council denied plaintiff's request for review. The ALJ found that prior to September 30, 1995, the date of last insured, plaintiff had severe optic neuritis and occasional right (dominant) below-the-elbow numbness, but that the impairments or combination thereof do not meet or medically equal a listed impairment; plaintiff's testimony is credible; plaintiff could perform her past relevant work; and plaintiff is not disabled. Administrative Transcript ("AT") 6-7. Plaintiff contends the ALJ improperly assessed the severity of plaintiff's impairments, improperly discredited her testimony, improperly rejected the opinion of a treating physician, and posed incomplete hypotheticals to the vocational expert.

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to disabled persons with low income. 42 U.S.C. § 1382 et seq. Under both provisions, disability is defined, in part, as an "inability to engage in any substantial gainful activity" due to "a medically determinable physical or mental impairment." 42 U.S.C. §§ 423(d)(1)(a) & 1382c(a)(3)(A). A five-step sequential evaluation governs eligibility for benefits. See 20 C.F.R. §§ 423(d)(1)(a), 416.920 & 416.971-76; Bowen v. Yuckert, 482 U.S. 137, 140-42 (1987). The following summarizes the sequential evaluation:

> Step one: Is the claimant engaging in substantial gainful activity? If so, the claimant is found not disabled. If not, proceed to step two.
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> Step two: Does the claimant have a "severe" impairment? If so, proceed to step three. If not, then a finding of not disabled is appropriate.
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> Step three: Does the claimant's impairment or combination of impairments meet or equal an impairment listed in 20 C.F.R., Pt. 404, Subpt. P, App.1? If so, the claimant is automatically determined disabled. If not, proceed to step four.
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> Step four: Is the claimant capable of performing his past work? If so, the claimant is not disabled. If not, proceed to step five.
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> Step five: Does the claimant have the residual functional capacity to perform any other work? If so, the claimant is not disabled. If not, the claimant is disabled.

Lester v. Chater, 81 F.3d 821, 828 n.5 (9th Cir. 1995).

The claimant bears the burden of proof in the first four steps of the sequential evaluation process. Bowen, 482 U.S. at 146 n.5. The Commissioner bears the burden if the sequential evaluation process proceeds to step five. Id.

II. Standard of Review

The court reviews the Commissioner's decision to determine whether (1) it is based on proper legal standards under 42 U.S.C. § 405(g), and (2) substantial evidence in the record as a whole supports it. Copeland v. Bowen, 861 F.2d 536, 538 (9th Cir. 1988) (citing Desrosiers v. Secretary of Health and Human Services, 846 F.2d 573, 575-76 (9th Cir. 1988)). Substantial evidence means more than a mere scintilla of evidence, but less than a preponderance. Saelee v. Chater, 94 F.3d 520, 521 (9th Cir. 1996) (citing Sorenson v. Weinberger, 514 F.2d 1112, 1119 n.10 (9th Cir. 1975)). "It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 402, 91 S. Ct. 1420 (1971) (quoting Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229, 59 S. Ct. 206 (1938)). The record as a whole must be considered, Howard v. Heckler, 782 F.2d 1484, 1487 (9th Cir. 1986), and both the evidence that supports and the evidence that detracts from the ALJ's conclusion weighed. See Jones v. Heckler, 760 F.2d 993, 995 (9th Cir. 1985). The court may not affirm the ALJ's decision simply by isolating a specific quantum of supporting evidence. Id.; see also Hammock v. Bowen, 879 F.2d 498, 501 (9th Cir. 1989). If substantial evidence supports the administrative findings, or if there is conflicting evidence supporting a finding of either disability or nondisability, the finding of the ALJ is conclusive, see Sprague v. Bowen, 812 F.2d 1226, 1229-30 (9th Cir. 1987), and may be set aside only if an improper legal standard was applied in weighing the evidence, see Burkhart v. Bowen, 856 F.2d 1335, 1338 (9th Cir. 1988).

III. Analysis

Plaintiff assigns four errors to the ALJ's analysis. Dispositive, however, is the challenge to the ALJ's assessment of plaintiff's credibility. The ALJ determines whether a disability applicant is credible, and the court defers to the ALJ's discretion if the ALJ used the proper process and provided proper reasons. See, e.g., Saelee v. Chater, 94 F.3d 520, 522 (9th Cir. 1995). If credibility is critical, the ALJ must make an explicit credibility finding. Albalos v.

Sullivan, 907 F.2d 871, 873-74 (9th Cir. 1990); Rashad v. Sullivan, 903 F.2d 1229, 1231 (9th Cir. 1990) (requiring explicit credibility finding to be supported by "a specific, cogent reason for the disbelief").

In evaluating whether subjective complaints are credible, the ALJ should first consider objective medical evidence and then consider other factors. Bunnell v. Sullivan, 947 F.2d 341, 344 (9th Cir. 1991) (en banc). If there is objective medical evidence of an impairment, the ALJ then may consider the nature of the symptoms alleged, including aggravating factors, medication, treatment and functional restrictions. See id. at 345-47. The ALJ also may consider: (1) the applicant's reputation for truthfulness, prior inconsistent statements or other inconsistent testimony, (2) unexplained or inadequately explained failure to seek treatment or to follow a prescribed course of treatment, and (3) the applicant's daily activities. Smolen v. Chater, 80 F.3d 1273, 1284 (9th Cir. 1996); see generally SSR 96-7P, 61 FR 34483-01; SSR 95-5P, 60 FR 55406-01; SSR 88-13. Work records, physician and third party testimony about nature, severity and effect of symptoms, and inconsistencies between testimony and conduct also may be relevant. Light v. Social Security Administration, 119 F.3d 789, 792 (9th Cir. 1997). A failure to seek treatment for an allegedly debilitating medical problem may be a valid consideration by the ALJ in determining whether the alleged associated pain is not a significant nonexertional impairment. See Flaten v. Secretary of HHS, 44 F.3d 1453, 1464 (9th Cir. 1995). The ALJ may rely, in part, on his or her own observations, see Quang Van Han v. Bowen, 882 F.2d 1453, 1458 (9th Cir. 1989), which cannot substitute for medical diagnosis. Marcia v. Sullivan, 900 F.2d 172, 177 n.6 (9th Cir. 1990). "Without affirmative evidence showing that the claimant is malingering, the Commissioner's reasons for rejecting the claimant's testimony must be clear and convincing." Morgan v. Commissioner of Social Sec. Admin., 169 F.3d 595, 599 (9th Cir. 1999).

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Plaintiff testified that during the relevant time period,[2] she needed to lie down during the day at least five days a week, her energy level was nonexistent, she was confined to a wheelchair, she had pain from head to toe with muscle spasms, severe deep leg pains, paralysis and numbness, she needed help with even the most basic of tasks such as hygiene, showering and brushing her hair, she had severe headaches constantly and could not see out of her right eye and she lost her balance all the time. AT 372-375. The ALJ did not assess the credibility of the above-described testimony under the standards set forth above, expressly finding there was "no reason to discredit [plaintiff's] testimony." AT 16. Rather, the ALJ found credibility was "not a factor insofar as the allegations of multiple sclerosis-related complaints prior to September 30, 1995, because of the absence of a medically determinable impairment which could reasonably have accounted for those complaints at that point in time." AT 16.

This finding is in error. The ALJ erroneously relied on the lack of a definitive diagnosis[3] of multiple sclerosis in 1995 as the basis for the finding there was no medically determinable impairment that could account for plaintiff's symptoms as she described them for the relevant time period. However, in so doing, the ALJ ignored specific signs and laboratory findings from 1995 that support plaintiff's complaints. See 20 C.F.R. § 404.1528 (statements of plaintiff must be supported with signs shown by medically acceptable clinical diagnostic

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[2] Plaintiff's date of last insured for disability benefits is September 30, 1995. Plaintiff must demonstrate disability on or before this date. AT 12.

[3] Although the plaintiff in a Social Security case sometimes erroneously argues that a medical diagnosis of a physical or mental condition necessarily compels a conclusion that an impairment exists, the obverse, that a definitive medical diagnosis must be made before an impairment can be found, is equally untrue. The governing regulations employ the term "impairment," not "diagnosis." See generally 20 C.F.R. §§404.1505 et seq. An "impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques." 20 C.F.R. § 404.1508. It is true that a plaintiff claiming disability at step three of the sequential analysis by meeting Listing 11.09 must first establish a diagnosis of multiple sclerosis. The failure to meet or equal that listing, however, does not preclude a finding of neurologic impairment at step two of the sequential analysis.

techniques and laboratory findings by accepted laboratory diagnostic techniques). Plaintiff was diagnosed in 1995 with retrobulbar neuritis. AT 124, 127, 132, 143. The MRI scan of May 31, 1995 was "suspicious" if not abnormal. AT 127, 130-131 (enhancement along the optic nerve or nasal to the optic nerve on the right side), 361 (two non-specific T2-brights foci in the corpus callosum). In July 1995, plaintiff was found to have slight pallor of the right optic nerve and her cranial nerves were decreased on the right greater than the left on I, V, VII, and VIII. AT 126. All of these signs and laboratory findings are consistent with plaintiff's objective complaints of a neurological impairment even if a definitive diagnosis of multiple sclerosis could not be made in 1995.[4] See Merck Manual 1474-76 (Seventeenth Ed.) (most common presenting symptoms and signs of multiple sclerosis include paresthesia, retrobulbar optic neuritis, stiffness or unusual fatigability of a limb, minor gait disturbances, optic nerve atrophy with pallor, numbness--signs often occur months or years before disease is recognized; MRI may show plaques). Plaintiff's testimony is also supported by the medical opinions of record.[5] See, e.g., AT 127 (probably demyelinating disease), 361-362 (right eye pain, blurry vision, left-sided weakness, numbness, pallor on right optic nerve, optic neuritis, and abnormal MRI compatible with multiple sclerosis but insufficient to definitively diagnosis under Poser's criteria), 44, 356 (probable multiple sclerosis in 1995 or possibly earlier). Plaintiff's testimony also is consistent with the subjective symptoms reported in the medical records and by her husband. AT 84, 87, 121, 124, 125, 142-143, 237, 264; see 20 C.F.R. § 404.1528(a) (medical findings consist of symptoms, signs and

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[4] A definitive diagnosis of multiple sclerosis requires two separate neurologic episodes with clinically confirmed findings separated by at least one month. AT 361-362. Because of the relapsing/remitting nature of the disease and a lack of insurance coverage, a definitive diagnosis was not made until 1999. AT 229, 373-374.

[5] Plaintiff also challenges the ALJ's analysis of Dr. Waubant's opinion, a treating physician who saw plaintiff after the relevant time period. The ALJ did not reject Dr. Waubant's opinion but merely noted Dr. Waubant could not make a retrospective definitive diagnosis. AT 13, 15. It appears the ALJ ignored the subsequently rendered opinion of Dr. Waubant that plaintiff had probable multiple sclerosis in 1995 or possibly earlier. AT 44. As discussed above, the lack of a definitive diagnosis of multiple sclerosis cannot support a finding plaintiff had no neurological impairment during the relevant time period.

laboratory findings); see also Smolen, 80 F.3d at 1284-85 . Because there were objective signs and laboratory findings consistent with the physical impairments testified to by plaintiff, the ALJ's rejection of plaintiff's testimony that she suffered debilitating symptoms in 1995 is in error. See 20 C.F.R. § 404.1529.

The remaining question is whether to remand this case to the ALJ or to order the payment of benefits. "The decision whether to remand the case for additional evidence or simply to award benefits is within the discretion of the court." Stone v. Heckler, 761 F.2d 530, 533 (9th Cir. 1985). Generally, the court will direct the award of benefits "in cases where no useful purpose would be served by further administrative proceedings or where the record has been thoroughly developed." Varney v. Secretary of Health and Human Services, 859 F.2d 1396, 1399 (9th Cir. 1988).

In this case, remand for immediate payment of benefits is appropriate. The ALJ failed in his duty to properly assess plaintiff's credibility and the court declines to remand the action for further credibility findings. Plaintiff's testimony, if credited, is inconsistent with the ability to perform work-related activities on a sustained basis of 8 hours a day, 5 days a week. See SSR 96-9p. No further development of the record is necessary. For the foregoing reasons, this matter will be remanded under sentence four of 42 U.S.C. § 405(g) for immediate payment of benefits.

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Accordingly, IT IS HEREBY ORDERED that:

1. Plaintiff's motion for summary judgment is granted.

2. The Commissioner's cross-motion for summary judgment is denied.

3. This action is remanded to the Commissioner for immediate payment of benefits.

DATED: September 30, 2005.

UNITED STATES MAGISTRATE JUDGE

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